State Board of Health

12 VAC 5-405

Rules Governing Private Review Agents

Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
3600 West Broad Street, Suite 216
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Copies of these regulations may be obtained from the:

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Chapter 405
Rules Governing Private Review Agents

12 VAC 5-405-10. Purpose.

The purpose of this chapter is to implement Article 2.1 (§§ 32.1-138.6 et seq.) of the Code of Virginia with respect to private review agents.

This chapter is designed to:

1. Provide minimum qualifications for private review agents operating in this Commonwealth;

2. Provide guidelines for the protection of consumers regarding the confidentiality of medical records; and

3. Promote the delivery of quality health care in a cost effective manner.

12 VAC 5-405-20. (*Reserved.*)

12 VAC 5-405-30. Scope.

This chapter applies to all private review agents performing utilization review in this Commonwealth. This chapter does not apply to insurers, health services plans, hospital service corporations, preferred provider organizations, or health maintenance organizations conducting utilization reviews solely for their own insureds, subscribers, members, or enrollees. This chapter does not apply to a private review agent in its conduct of utilization review for self-insured groups or a private review agent in its fulfillment of a contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act (Public Law 89-97, 79 Stat 286 (July 30, 1965)) or in its fulfillment of a contract with a plan otherwise exempt from operation of Article 2.1 (§32.1-138.6 et seq.) of Chapter 5 of Title 32.1of the Code of Virginia pursuant to the Employee Retirement Income Security Act of 1974 (29 USC §1001 et seq.). This chapter does not apply to utilization review conducted in Worker's Compensation claims or bodily injury liability claims, including uninsured motorist claims. This chapter does not apply to utilization reviews conducted by a provider peer review organization solely for the use of such organization or its members.

12 VAC 5-405-40. Definitions.

For the purposes of this chapter:

"Adverse decision" means a utilization review determination by the private review agent that a health service rendered or proposed to be rendered was or is not medically necessary when such determination may result in noncoverage of the health service or health services. If the provider and private review agent reach agreement prior to the issuance of an adverse decision, then no adverse decision has occurred.

"Attending physician" means the physician with primary responsibility for the care subject to review.

"Business days" means all days other than weekends and legal holidays.

"Certificate" means a certificate of registration granted by the Department to a private review agent.

“Department” means the Virginia Department of Health.

"Initial adverse recommendation" means a reviewer's recommendation, made prior to providing the attending physician a reasonable opportunity to consult with a physician advisor, that an adverse decision be issued.

"Insurer" means an insurance company, health services plan, health maintenance organization, preferred provider organization or multiple employer welfare arrangement.

"Operating in this Commonwealth" means providing utilization review services affecting insureds, subscribers, members or enrollees with respect to an insurance or subscription contract issued for delivery or delivered in Virginia.

"Peer" means a person who has an equivalent degree of education, skill, and licensure as another.

"Physician advisor" means a physician licensed to practice medicine who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities.

"Private review agent" means a person or entity performing utilization reviews, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization reviews solely for subscribers, policyholders, members or enrollees:

1. A health maintenance organization authorized to transact business in Virginia; or
2. A health insurer, hospital service corporation, health services plan or preferred provider organization authorized to offer health benefits in this Commonwealth.

"Provider" means an individual or organization that provides personal health services.

"Staff" means persons employed or under contract to perform utilization review on behalf of a private review agent.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, health maintenance organization or other entity or person. For the purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination and review related to the appropriateness of the site at which services were or are to be delivered.

"Utilization review" shall not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117 through 38.2-119, 38.2-124 through 38.2-126, 38.2-130 through 38.2-132 and 38.2-134.

"Utilization review program" means a program for conducting utilization reviews by a private review agent.

12 VAC 5-405-50. Certificates to perform utilization review.

A. Beginning July 1, 1998 a private review agent not operating in this Commonwealth shall obtain a certificate from the department prior to operating in this Commonwealth.

B. Private review agents operating in this Commonwealth prior to July 1, 1998 shall submit an application for a certificate on or before July 1, 1998.

C. An applicant for a certificate shall pay an application fee and shall submit an application to the department on the forms or in the manner prescribed by the department. The applicant shall also submit the following information required by §32.1-138.9 of the Code of Virginia:

1. A description of the procedures to be used in evaluating proposed or delivered hospital, medical or other health care services;
2. The procedures by which patients or providers may seek reconsideration of determinations by private review agents;
3. The type and qualifications of the staff either employed or under contract to perform the utilization review;
4. Procedures and policies which ensure that patient-specific medical records and information shall be kept strictly confidential except as authorized by the patient or by 12 VAC 5-405-100; and
5. Assurances that reviewers will be readily accessible by telephone to patients and providers at least 40 hours per week during normal business hours.

12 VAC 5-405-60. Fee for certificate.

A. Every private review agent shall pay an application fee of $500 and a biennial renewal fee of $500 to the department. Each certificate shall expire on June 30 of the appropriate year. Prior to April 1 of the renewal year, each private review agent shall remit a renewal application form and fee to the department.

B. The department may refuse to issue an agent's certificate to any person or may suspend or revoke the certificate of any certificate holder whenever it finds that the applicant or certificate holder:

1. Has failed to meet or maintain the requirements of §32.1-138.9 of the Code of Virginia;
2. Has violated any sections of this chapter;
3. Has failed to adhere to its procedures as submitted to the department;
4. Has violated any provisions of any law of this Commonwealth applicable to private review agents; or
5. Has been guilty of fraudulent or dishonest practices.

C. A certificate issued to a private review agent shall authorize him to act as a private review agent until his certificate expires or is otherwise terminated, suspended or revoked. The department shall not revoke or suspend an existing certificate until the certificate holder is given an opportunity to be heard before the department. If the department refuses to issue a new certificate or proposes to revoke or suspend an existing certificate it shall give the applicant or certificate holder at least 10 days' notice in writing of the time and place of the hearing if a hearing is requested. The notice shall contain a statement of the objections to the issuance of the certificate or the reason for its proposed revocation or suspension, as the case may be. The notice may be given to the applicant or certificate holder by registered or certified mail sent to the last known address of record. The department may summon witnesses to testify with respect to the applicant or certificate holder and the applicant or certificate holder may introduce evidence in its behalf. No applicant to whom a certificate is refused after a hearing, nor any certificate holder whose certificate is revoked shall again apply for a certificate until after the time, not exceeding two years, the department prescribes in its order.

12 VAC 5-405-70. Minimum qualifications of staff.

A. The staff of a private review agent responsible for making utilization review decisions (including nonadverse decisions), as a minimum, shall have qualifications equivalent to or exceeding those of Accredited Record Technicians (ARTs) as awarded by the American Medical Record Association. The staff of a private review agent who are responsible for making utilization review decisions and who are required to be licensed to practice their health care profession shall be licensed by a jurisdiction of the United States.

B. The private review agent shall have available the services of a sufficient number of medical records technicians, licensed practical nurses, registered nurses, or other similarly qualified professionals, supported and supervised by appropriate licensed physicians, to carry out its utilization review activities. The staff shall include nonphysician providers, as appropriate, and physicians in appropriate specialty areas. The physician staff shall include physicians who are board certified or board eligible.

12 VAC 5-405-80. Adverse decisions.

A. With the exception of adverse decisions made on the basis of retrospective review, prior to the issuance of an adverse decision, and if requested by the provider, the case in question must be reviewed either by a physician advisor or by a peer of the provider proposing the care. In addition, to the extent appropriate, the case in question must be reviewed in consultation with a physician advisor with experience in the same field of practice as the attending physician. The physician advisor or peer must be on the staff of the private review agent.

B. With the exception of retrospective reviews, the private review agent must make a reasonable attempt to communicate an initial adverse recommendation to the attending physician prior to the issuance of an adverse decision. With the exception of retrospective reviews, the private review agent must provide the attending physician a reasonable opportunity to consult with a physician advisor prior to the issuance of an adverse decision. Attending physicians and private review agents shall attempt to share the maximum information by telephone, facsimile machine, or otherwise prior to the issuance of an adverse decision.

C. Written notification of an adverse decision shall be given to the individual provider and provider organization and shall include the type of review performed, the reason for the adverse decision, the alternate length of treatment or the alternate treatment setting(s), if any, that the

private review agent would approve or would have approved, and a description of the appeal process. Written notification of an adverse decision shall be given to the patient and shall include a description of the appeal process. The description of the appeal process shall include relevant information including, but not limited to, time limits, addresses, and telephone and facsimile numbers. The insurer who contracts with the private review agent for utilization review may fulfill the notification requirements for the private review agent.

12 VAC 5-405-90. Appeals of adverse decisions.

A. Private review agents shall include in their procedures, an appeal process that can be utilized when an adverse decision is made. In addition to any notice provided to the patient by a private review agent, providers also may notify the patient of any adverse decision and providers may file an appeal on behalf of the patient. A private review agent and/or insurer may set a reasonable period of time after notification of an adverse decision within which an appeal must be filed.

B. Any case under appeal shall be reviewed by a physician advisor or peer of the provider who proposes the care under review or who was primarily responsible for the care under review. Chiropractic appeals shall be reviewed by a chiropractor. With the exception of expedited appeals, physician advisors who review cases under appeal must be board certified or board eligible and must be specialized in a discipline pertinent to the issue under review. Those who review cases under appeal must not have participated in the adverse decision being appealed.

C. When an adverse decision is made during ongoing treatment and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination by telephone on an expedited basis. Private review agents shall provide for reasonable access by providers to their physician advisor(s) for such appeals. Both providers and private review agents shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to satisfactorily resolve the expedited appeal. Expedited appeals which cannot resolve a difference of opinion may be reconsidered in the standard appeals process unless the physician advisor reviewing the case under expedited appeal meets the requirements set out in subsection B of this section for standard appeals, and all material information and documentation was reasonably available to the provider and to the private review agent at the time of the expedited appeal. The private review agent shall make decisions on expedited appeals within four business days of receiving all pertinent information.

D. The private review agent shall provide an opportunity during the appeal process for the provider to provide additional information and documentation. For appeals not subject to subsection C of this section, appeals will be made in writing or telephonically by the process established by the private review agent. Private review agents shall transmit their determination on the appeal as soon as practicable, but in no case more than 60 days after receiving the required documentation on an appeal. The required documentation may include among other things, copies of part or all of the medical record and/or a written statement from the provider. The private review agent shall provide that such documentation be reviewed by a physician advisor or peer of the provider individual who proposes the care under review or who was primarily responsible for the care under review. In the case of chiropractic appeals, such documentation shall be reviewed by a chiropractor. A provider who has been unsuccessful in overturning an adverse decision has the right to request of the private review agent the medical basis for that determination. The private review agent shall furnish the support for that determination within 30 business days.

12 VAC 5-405-100. Access to and confidentiality of medical records and information.

A. Private review agents who have been granted a certificate by the department shall have reasonable access to patient specific medical records and information.

B. The private review agent's procedures shall specify that specific information exchanged for the purpose of conducting review will be considered confidential, be used by the private review agent solely for the purposes of utilization review, and shared by the private review agent with only those parties who have authority to receive such information, such as the claim administrator. The private review agent's process shall specify that procedures are in place to assure confidentiality and that the private review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual patients or providers need not be considered confidential.

C. When consistent with the subsection B of this section and federal and state statutes and regulations, patient specific data gathered by the private review agent which raises questions of deficiencies in quality may be shared with the hospital's or other facility's Quality Assurance Committee. Prior to the sharing of such information, a private review agent may require the hospital or other facility to assure compliance with confidentiality requirements, to assure the appropriate review and follow-up within that hospital's or other facility's Quality Assurance

Committee, and to indemnify the private review agent from inappropriate use of such information.

D. Chapter 6 (§38.2-600 et seq.) of Title 38.2 and §32.1-127.1:03 of Title 32.1 of the Code of Virginia shall apply to private review agents. Prior to the release of patient-specific information to a private review agent, a patient shall provide written consent for the release of such information. If the patient will not authorize the release of information, or has refused to sign the release of information forms, the private review agent may then follow its own policy or that of the insurer regarding that refusal.

E. Medical records and patient specific information shall be maintained by the private review agent in a secure area with access limited to essential personnel only.

F. Information generated and obtained by private review agents in the course of utilization review shall be retained for at least five years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened.

12 VAC 5-405-110. Accessibility.

A. A private review agent shall provide free telephone access to patients and providers at least 40 hours per week during normal business hours. Private review agents must have a mechanism for informing patients and providers of the eastern time zone hours during which those agents are accessible; such eastern time zone hours shall be no less than 40 hours per week during normal business hours.

B. It is the responsibility of the private review agent to install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour information for incoming calls outside of normal business hours.

C. The department may determine, upon written request, that other telephone systems are adequate in special circumstances.

12 VAC 5-405-120. Examination of private review agents.

A. The department may conduct reviews of the operations of private review agents operating in this Commonwealth to determine if the private review agent is operating in compliance with this chapter and Article 2.1 (§32.1-138.6 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia. The reviews may include telephone audits to determine if the private review agents are accessible as required by this chapter.

B. The department may investigate any complaint from a health care provider or patient regarding the compliance of a private review agent with the requirements of this chapter or Article 2.1 of Chapter 5 of Title 32.1 of the Code of Virginia.

C. The investigation of private review agents shall not include individual determinations of medical necessity or appropriate charges for covered services. If there is evidence which indicates an alleged pattern of misconduct with respect to utilization review performed by a private review agent, the department may take such action it deems appropriate to correct such pattern of misconduct.